Montana Medicaid CLAIM JUMPER

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New Strategic Direction for Health-e-Web

Health-e-Web (HeW), Inc., known for its electronic healthcare transaction clearinghouse, is setting a new strategic direction beginning January 1, 2006 when it becomes a fully staffed subsidiary. HeW will enhance partnerships with health care providers, employers, and insurance carriers by offering a wide variety of products and services that will help contain health care costs. As part of this strategy, HeW will eliminate the EDI surcharge required to send Montana Medicaid/ACS transactions electronically in 2006. Clients will be required to enter into a new contract arrangement with HeW to take advantage of this benefit. The new contract arrangement includes a new pricing model, which gives clients the ability to take advantage of enhanced products and services for a low fixed monthly fee.

"Operationally, the changes should be transparent to HeW's clients. Our focus remains on customer service, and the most notable change will be related to the expansion of products and services offered by the company," said Bob Janicek, Director of HeW. According to Janicek, "Our staff, who is responsible for HeW's ongoing success, will provide our customers with the highest level of customer service. As a Montana company, we believe that our service will set us apart from other vendors and clearinghouses entering the Montana market."

More information will be available over the next few months that will demonstrate how HeW is "Bringing Service into Perspective!".

Submitted by
Deb Redmond, Health-e-Web

Self Directed Personal Assistance Services

Self Directed Personal Assistance Services are available to consumers who are capable of managing and willing to manage their attendant services. The consumer has the responsibility to recruit, hire, train, manage, schedule and discharge the attendants. The Medicaid provider agency insures that Medicaid is billed and the attendant is paid. Self Direct consumers receive personal care, meal preparation, household tasks and escort and additionally have the option of managing appropriate health maintenance activities. These activities include bowel, bladder programs, wound care and medication administration.

The form DPHHS-SLTC-160, titled Self-Directed Personal Assistance Services Health Care Professional Authorization is critical for delivery of services. Annually the consumer's Health Care Professional MUST recertify by signing the form that the consumer can direct their care. The Health Care Professional's signature is required by the end of the month that the annual review is due. It is the responsibility of the consumer to have the Health Care Professional sign the form. If the form with the Health Care professional signature has not been returned to the consumer's personal assistance agency, the consumer will not be able to receive any Medicaid personal assistance services. It is imperative that the Health Care Professional sign the form in a timely matter so not to jeopardize the steady stream of personal care services for the consumer.

Submitted by Denise King, DPHHS

Billing with an Incurment Amount

If a provider, other than a pharmacy, sees a patient who has an incurment, the patient is responsible for the amount of the incurment. To ensure proper credit on claims, the following guidelines must be adhered to:

* Providers must bill using the incurment date (found on the incurment letter from the Office of Public Assistance) as the first date of service if the service was performed on that date.
* Providers should not enter the incurment information anywhere on the claim. It is not self-pay information, nor is it considered a 'previous payment.' The processing system will calculate the incurment amount in determining reimbursement.
* It is not necessary to include a copy of the incurment form with the claim.

Provided that the claim is billed with the correct date of service, the MMIS will take the appropriate incurment and pay the claim minus the patient's responsibility.

Pharmacies should submit their claims in the usual manner. They will then be paid for the entire prescription. Pharmacy providers must then write a check to DPHHS for the amount that should be collected from the patient (the incurment minus any additional cost share amount), attach a copy of the incurment letter from the Office of Public Assistance, and mail all documentation to ACS. A system change is in process to automatically deduct the incurment amount for pharmacy claims. Please watch the Claim Jumper for updates related to this change.

If there are any questions about the processing of incurments, please contact Provider Relations at 406-442-1837 or 800-624-3958.

Submitted by ACS

Paperwork Document Submissions

Paperwork which is submitted to be warehoused for future claim use does not need to be submitted more than once. When received, the document is scanned under the client identification number sent on the paperwork attachment cover sheet or the claim to which it was attached, where it is then available for other providers' use. Once scanned, claims that are pended for specific paperwork (i.e. sterilization forms and retroactive eligibility forms) will be matched up with the appropriate form and processed accordingly. The client ID number submitted on the claim must match the client ID number under which the attachment was scanned.

Paperwork attachments can also be submitted with claims. Attachments that are sent with claims for processing are now being scanned under the appropriate client ID for future use as well as being used for that particular claim.

If you are submitting a paperwork attachment that should be married to a claim, this paperwork only needs to be submitted once as well. It must be accompanied by a paperwork attachment cover sheet which can be found on the Montana Medicaid website (www.montanamedicaid.org). This form includes identifying claim information which will allow the attachment to be utilized to process the claim.

If you have any questions or concerns about paperwork attachments, please contact Provider Relations at 800-624-3958 or 406-442-1837.

Submitted by ACS

Cost Share and Previous Payment Amount Indicators

Self-pay amounts should not be notated on claims that are submitted either electronically or on paper. If claims are billed electronically, the TPL indicator should be left blank. Self-pay should not be indicated, nor should the cost share information be entered on the claim. The MMIS will take the appropriate cost share automatically.

The field for previous payments on a professional claim should only be filled with prior TPL information and only if the client has any TPL. If the claim is a facility claim, and the client has Part A Medicare, this information can be on the face of the claim. This information can be entered in field 29 on a CMS 1500 or form locator 54 on a UB92. If billing electronically, the information should be reported in Loop 2430 SVD02 (Payer Paid Amount). Any private pay information that is entered in those boxes will cause the claim to pay incorrectly. MMIS automatically takes the appropriate cost share amount, and will take it twice if the amount is entered as a previous payment.

If you have any questions about cost sharing, please see the December Claim Jumper, or call Provider Relations at 1-406-442-1837 or 1-800-624-3958.

Submitted by ACS

Medicare Part D: Exceptions and Appeals

Medicare prescription drug plans are required to provide enrollees with materials that clearly explain the exceptions and appeals processes.

An enrollee may ask his or her drug plan for an exception if:

- The doctor or pharmacist says the drug plan will not cover a prescription drug in the amount or form prescribed by the doctor;
- The doctor or enrollee believes a drug is needed that is not on the drug plan's formulary; or
- The enrollee is asked to pay a cost

share amount that is higher than $1 for generics or $3 for brand-name drugs. This cost share level applies to dual-eligible individuals only (those with both Medicare and Medicaid). Other enrollees may have higher cost shares.

When contacting a drug plan for an exception, an enrollee needs to have the following information:

- The prescription drug(s) needed.
- The name of the pharmacy or physician who said the prescription drug(s) is not covered.
- The date the enrollee was told the prescription drug(s) is not covered.

If the Part D plan's initial coverage determination of the request for an exception is unfavorable, Medicare Part D provides five levels of appeals:

- Level 1: Redetermination by the Part D plan. Expedited appeal time frame is 72 hours, standard appeal time frame is 7 days. An expedited decision is requested based on the urgency of an enrollee's health condition.
- Level 2: Reconsideration by an Independent Review Entity, a Medicare contractor. Expedited appeal time frame is 72 hours, standard appeal time frame is 7 days.
- Level 3: Hearing with an Administrative Law Judge
- Level 4: Medicare Appeals Council, an entity within the federal Department of Health and Human Services.
- Level 5: Federal District Court.

Other important information
Dual-eligible individuals were randomly enrolled in a Medicare prescription drug plan by Medicare; they can stay in that plan or change any time to another standard plan that better meets their needs.

For a list of standard plans to which dual-eligible individuals can change and pay no premium, see www.MTMedicaid.org.

To find the Medicare prescription drug plan in which a Medicare beneficiary is currently enrolled, go to www.Medicare.gov, select the Medicare Prescription Drug Plan Finder, then select "Find a Medicare Prescription Drug Plan." You will need the following information from the enrollee's Medicare card: Medicare claim number, last name, date of birth, effective date for Part A or Part B, and zip code.

As with any new initiative, the change to Medicare Part D may present challenges or glitches. DPHHS and ACS want to help make the transition as smooth as possible for dual-eligible enrollees. If you have questions or need additional information, please contact Mary Noel, Fiscal and Policy Coordinator for the Department, at 444-2584 or manoel@mt.gov.

Submitted by Mary Noel, DPHHS

Erectile Dysfunction Drugs

Effective January 1, 2006

Federal Legislation (HR 3971) was passed eliminating Medicaid coverage of drugs used for treatment of sexual or erectile dysfunction (ED). This legislation amended Section 1927(d)(2) of the Social Security Act (42 U.S.C. 1396r-8(d)(2)) by adding language allowing states to exclude coverage of these drugs, unless they are provided for treatment of a condition other than sexual or erectile dysfunction that is an FDA approved use of the drug. Unlike other drugs listed in section 1927(d)(2), the language also eliminates federal funding for coverage of these drugs for sexual or erectile dysfunction. Therefore, Montana Medicaid will eliminate coverage of ED drugs for these restricted uses.

Montana Medicaid will continue to cover sildenafil for pulmonary hypertension with a prior authorization.

The prescriber (physician, etc.) or pharmacy may submit requests by mail, telephone, or FAX to:

Drug Prior Authorization Unit
Mountain Pacific Quality Health Foundation
3404 Cooney Drive
Helena, MT 59602
(406) 443-6002 or (800) 395-7961 (Phone)
(406) 443-7014 or (800) 294-1350 (Fax)

To request prior authorization, providers must submit the information requested on the Request for Drug Prior Authorization Form to the Drug Prior Authorization Unit. This form can be copied from page 5.9 of the Medicaid Prescription Drug Program Manual on the web at: http://www.dphhs.state.mt.us/hpsd/medicaid/medicaid2/pdf/pharmacy.pdf

Any questions regarding this notice can be directed to Dan Peterson at (406) 444 2738 or the Medicaid Drug Prior Authorization Unit at (406) 443 6002.

Submitted by Dan Peterson, DPHHS

Web Portal Makes Team Care Verification Easy

The new Montana Access to Health Web Portal has immensely increased the ease of verifying Team Care eligibility. Gone are the days of questioning a Team Care client's enrollment status, assigned primary care provider (PCP), or "lock-in" pharmacy. The Portal's verification system is 100% accurate as it gives a look into Medicaid's claim adjudication system.

Team Care is a subset of the PASSPORT To Health program; all Team Care clients are enrolled in PASSPORT. When checking for eligibility, the "Managed Care Information

– Plan Coverage Description" will show "TEAM CARE." PCP and Pharmacy provider sections indicate the client's Team Care provider and locked-in pharmacy, along with their phone numbers and effective enrollment dates.

Remember, Team Care rules mimic PASSPORT, and all PASSPORT rules and guidelines must be followed. But we do ask you to take a more active roll in managing Team Care clients by requiring them to call the Nurse First Advice Line prior to calling your office, by carefully considering referrals for Team Care clients, and by writing prescriptions only to the client's Team Care Pharmacy. And don't forget about the "Team Care Fax" sent to you by the Nurse First Advice Line, which outlines their recommendation to your Team Care client. The Team Care Fax has proven to be a valuable asset for the busiest offices.

For Team Care program information, contact Chris Silvonen in the Montana Medicaid Managed Care Bureau at (406) 444-1292, or e-mail him at csilvonen@mt.gov. With your continued assistance, we can help Team Care clients get the right care at the right time at the right place.

Submitted by Anastasia Burton, DPHHS

Tips for Processing with OCR

During April paper claims received by Medicaid began to be processed using an Optical Character Recognition system (OCR). CMS 1500 claims began in April and UB92 claims were added to OCR in late July. The OCR process uses a computer to 'read' the information from the claim instead of being manually data entered. This process improves accuracy and increases the speed at which claims are entered into the claims processing system.

One major change that providers will notice is the amount of time claims are in suspense. Prior to the implementation of the OCR solution paper claims were entered into the claims processing system approximately three weeks after they were received. Then a majority of the suspense was resolved at the time of entry. With the OCR solution paper claims are normally entered within one week of receipt and no suspense is resolved at the time of entry. This causes claims to appear on the SOR much faster than without OCR. Claims that were previously held as unkeyed on a shelf are now being held in a pended status in the claims processing system. Once the exceptions have been resolved the claims will be reported as paid or denied on the SOR.

The following list of Do's and Don'ts will aid you in decreasing processing times for paper claims.

Do

- Use an original, standard red-dropout form (HCFA, UB, etc.)
- Use machine (typewritten) print
- Use a clean, non-proportional font
- Use black ink
- Print claim data within the defined boxes on the claim form
- Print only the information asked for on the claim
- Use all capital letters
- Use a laser printer for best results
- Use white correction tape for corrections
- Submit notes on 8½" x 11" paper
- Use an 8-digit date format (e.g., 10212004)

Don't

- Don't use stamps, labels, or stickers
- Don't include narrative comments in diagnosis fields
- Don't hand print or hand write your forms; if you must hand print, use neat block letters that stay within field boundaries. Information not clearly within defined field boundaries may process incorrectly.
- Don't use copies of claim forms
- Don't use dashes or slashes in date fields.
- Don't use fonts smaller than 8 point
- Don't use a dot matrix/impact printer, if possible
- Don't use correction fluid
- Don't put notes on the top or bottom of the claim form
- Don't enter "none", "NA" or "Same" if there is no information; just leave the box blank
- Don't fold claim forms
- Don't use proportional fonts (Courier is a good example of a font that is not proportional)
- Don't use mixed fonts on the same form
- Don't use italics or script fonts
- Don't print slashed zeros
- Don't use highlighters to highlight field information

Submitted by ACS

New Release for Montana Access to Health Web Portal

ACS has implemented the second release of the web portal to production. Providers can now download their RA (e!SOR) reports. These are downloadable in a PDF format and will be available for 90 days at which time they will be purged from the web portal. The RA reports were loaded back to the October 17th payment date.

ACS is excited for providers to now have the option to view and save their RAs on line. If you encounter any problems with the web portal, please contact Provider Relations at 1-800-624-3958.

Submitted by ACS

Recent Publications

The following are brief summaries of recently published Medicaid information and updates. For details and further instructions, download the complete document from www.mtmedicaid.org, the Provider Information website. Select ***Resources by Provider Type*** for a list of resources specific to your provider type. If you cannot access the information, contact Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena or out-of-state.

Recent Publications Available on Website		
Date	**Provider Type**	**Description**
Notices		
11/09/05	Hospice	Revised Rate Increase
12/02/05	Physician, Pharmacy, Mid-Level Practitioner	Coverage of Drugs for Sexual or Erectile Dysfunction Eliminated
Fee Schedules		
11/09/05	Hospice	FY2006 Fee Schedule
11/29/05	Hospital - Outpatient	APC Fee Schedule
11/29/05	Hospital - Outpatient	Procedure Code Fee Schedule
Other Resources		
11/07/05	All Provider Types	What's New on the Site This Week?
11/08/05	All Provider Types	PASSPORT to Health Client Newsletter
11/08/05	PASSPORT to Health	Revised Child Survey Question by Question
11/08/05	Pharmacy	Updated PDL and Quicklist
11/08/05	All Provider Types	Link to Montana Access to Health Tutorial
11/15/05	All Provider Types	What's New on the Site This Week
11/15/05	Outpatient Hospital	Prospective Payment System Billing Guide (PowerPoint)
11/15/05	Pharmacy	Updated PDL and Quicklist
11/15/05	Inpatient Hospital	DRG Relative Values, Average Length of Stay, and Outlier Thresholds
11/16/05	All Provider Types	* Medicare Prescription Drug Coverage Personal Information Worksheet for People with Medicare and Medicaid * Choosing a Medicare Drug Plan for People with Medicare and Medicaid * People with Medicare and Medicaid: Medicare Will Enroll you in a Plan Automatically. How Do You Find Out Which Plan
11/21/05	All Provider Types	What's New on the Site This Week
11/21/05	All Provider Types	December Claim Jumper
11/21/05	PASSPORT to Health	Updated FAQs
11/21/05	All Provider Types	PDF of all FAQs
11/28/05	All Provider Types	What's New on the Site This Week
11/29/05	Inpatient Hospital, Outpatient Hospital, Mid-Level Practitioner, Physician, All other providers except Ambulance and Pharmacy	Updated Remittance Advice Notices
11/30/05	School-Based Services	Revised MAC Agreement Memorandum of Understanding
12/02/05	All Provider Types	Stand-Alone Prescription Drug Plans Eligible to Receive Auto-Enrolled Beneficiaries in Montana

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Key Contacts

Provider Information website: http://www.mtmedicaid.org
ACS EDI Gateway website: http://www.acs-gcro.com
ACS EDI Help Desk (800) 624-3958
Provider Relations
(800) 624-3958 (In and out-of-state)
(406) 442-1837 (Helena)
(406) 442-4402 Fax
TPL (800) 624-3958 (In and out-of-state)
(406) 443-1365 (Helena)
(406) 442-0357 Fax
Email: MTPRHelpdesk@ACS-inc.com
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944
PASSPORT (800) 624-3958
Prior Authorization
DMEPOS (406) 444-0190
Mountain-Pacific Quality Health Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

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